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Franklin Memorial Hospital/NorthStar EMS

NOTICE OF EXCLUSION FROM MEDICARE BENEFITS (NEMB)

(Applicable to Medicare Beneficiaries only)

Even though we offer to provide the service, there are items and services for which Medicare will not pay.

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully. Ask us to explain if you do not understand why Medicare won't pay.

|____| Medicare will not pay for your ambulance transport because you could be transported by another means of transportation (whether that means of transportation is available or not.) Based on your situation, either an ambulance transport is not considered "Medically Necessary"*, or the destination of the transport is not to a covered facility (for instance, transport to a physician's office), or the service at the destination is not a covered service.

|____| Medicare will not pay for ambulance transport beyond the nearest appropriate facility equipped to medically treat the patient. Based on your situation, the transportation (mileage) beyond the closest appropriate facility would not be a covered benefit.

We *estimate* that the cost of this ambulance transport, should you decide to be transported by ambulance, is $__________________**.

I wish to be transported by ambulance and I understand that Medicare will not pay for all or part of this ambulance transport.

___ By checking this box, I authorize FMH to bill Medicare to generate a denial determination

____ Date: ____________________

Patient (or authorized signature):

|__| Patient/authorized party advised, no signature. Attested by: ___________________________ Date: ___________

*See the reverse side for a discussion of "medical necessity". Medical necessity is determined by the condition of the patient and the equipment or skills necessary during the transport. A Physician Certification Statement (PCS) is required for all transfers.

**Fees eff. July 1, 2009: BLS-xfer: $536, BLS-Emerg: $728, ALS-xfer: $620, ALS-Emerg: $929, PIFT: $1,571, All transports: $22 per mile. (fees subject to change)

To aid in understanding **<u>Medicare's</u>** Medical Necessity and Coverage Limits, below is a summary of the Medicare Payment rules (from the Medicare Benefit Policy Manual).

<u>Medical Necessity</u> for **Medicare Patients** is established when the patient's condition is such that use of any method of transportation *other than* an ambulance is contraindicated. If a means of transportation other than an ambulance could be used without endangering the individual's health, *<u>whether or not such other transportation is actually available</u>*, **Medicare will likely not pay and the patient will be billed directly**. The presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. Also the *reason* for the transport must be medically necessary (i.e., the transport must be to obtain a Medicare covered service or return from such a service.)

Medical necessity is presumed to be met if the individual was **bed-confined** before <u>and</u> after the ambulance trip. Bed-confinement is defined specifically as: "unable to get up from bed without assistance *and* unable to ambulate *and* unable to sit in a chair or wheelchair." But even bed confinement, by itself, is only one of the determining factors of medical necessity. The rule for medical necessity is stated above: Is the ambulance necessary for the patient's health?

Only the following destinations are covered (and all are subject to the medical necessity rule): Hospitals, Skilled Nursing Facilities, Home, Dialysis for ESRD patients. Transporting a patient by ambulance to a physician's office is not a covered benefit unless it is for the dire emergency need of professional attention on the way to a hospital.

Furthermore, only "local" transportation by ambulance is covered. Thus, only mileage to the nearest *appropriate* facility equipped to treat the patient is covered. There is some latitude here but if the destination is <u>not</u> the nearest one, the documentation must be clear as the reason for taking the patient to the alternate destination. When two similar hospitals are about the same distance away or an alternate hospital is generally recognized to be a regular destination for that community for the type of symptoms presenting then either facility is considered "closest appropriate". The *documented* lack of beds for the type of patient (e.g. for mental health patients) or the *documented* fact that a further hospital was equipped and staffed for trauma or highly specialty care needed for the patient and not available closer may be valid reasons for going to a further destination. However, Medicare will <u>not</u> cover bypassing a similarly equipped hospital solely because of facility reputation, patient or physician choice. The excess mileage is the responsibility of the patient. All such alternate destinations must be fully documented as to the medical reason why the farther facility is necessary.

A Notice of Exclusion of Medicare Benefits (NEMB) must be completed and signed for any situation (*<u>emergency or non-emergency</u>*) where the patient is a **Medicare** beneficiary and:

- The patient's condition would allow them to be transported by a means other than ambulance (whether or not the other transportation is available)(show the appropriate fee plus estimated mileage in the space provided on the reverse)
- The patient (or physician) requests a destination beyond the closest appropriate facility (estimate the excess mileage to be charged to the patient)
- The service at the destination is not covered (appropriate level fee plus estimated mileage)

<u>If any of the above apply, the patient may not be transported unless the NEMB is completed and signed (or attested that the patient was made aware that Medicare may not pay).*</u>

*Note: If the trip is determined to be not medically necessary, the patient will be billed directly whether or not the NEMB is completed.